Government of **Western Australia**
Department of **Health**

Child Development Service (CDS) Referral Form

Child's surname: _____ **First name:** _____ M ☐ F ☐

Address: _____ Suburb: _____ P/code: _____

Date of birth: ___ / ___ / ___ Age: _____ Medicare number: ☐☐☐☐ ☐☐☐☐☐ ☐ (if available)

Child's medical record number: (From child health record) ☐☐☐☐☐☐☐☐ (if available)

Mother's full name when she gave birth: _____

Is this child of Aboriginal descent? Y ☐ N ☐ Torres Strait Islander descent? Y ☐ N ☐

Has child attended a child development centre before? Y ☐ N ☐ Which centre? _____

Interpreter needed? Y ☐ N ☐ If yes, what language? _____

Parent/guardian for contact: Surname: _____ **First name:** _____

Phone: (Hm) _____ (Mob) _____ (Wk) _____

Reason for referral: (Please tick which of the following apply)

Fine motor	☐	Behaviour/emotion	☐	Functional skills (feeding, toileting, sleeping)	☐		
Gross motor	☐	Feet/lower limbs/gait	☐	Play skills	☐	General development	☐
Speech/language	☐	Head shape/position	☐	Learning	☐	Attention/concentration	☐
Family/relational	☐	Hearing	☐	Sensory	☐	Other	☐

Further details required for all reasons ticked: _____

Relevant health history: (Please attach any relevant test results/reports) _____

Additional comments: _____

Day care/school attending: _____ Yr: _____ Ph: _____

Teacher's name: _____ Has child seen a school psychologist? Y ☐ (Attach report) N ☐

Date of last hearing test: _____ Result: _____

Date of last vision test: _____ Result: _____

Other agencies involved: _____

Permission of parent/guardian (Only the child's legal guardian may provide consent. Consent must be obtained)

(Name of legal guardian) _____ gives permission for _____

to be referred to the Child Development Service. Relationship to child: _____

Signed: _____ Date: _____ [Verbal consent provided ☐]

Is this child in the care of the CEO of the Department for Child Protection (DCP)? Y ☐ N ☐

DCP Authorised Officer: _____ DCP Office: _____

Signed: _____ Date: _____ [Verbal consent provided ☐]

Referrer information: (Or referrer stamp/sticker) Date: _____

Title: _____ Surname: _____ First name: _____ Occupation: _____

Name of school/practice/health centre etc: _____

Address: _____ Suburb: _____ P/code: _____

Phone: _____ Fax: _____ Email: _____

Signature: (Teacher referrals to also be signed by Principal/Deputy/School Psychologist) _____

Attached documents/reports: _____

If you need assistance with this form or require an alternative format, contact your relevant CDS site.

Thank you for your referral. Please forward to the relevant Child Development Service site.

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